DELETION OF COVERAGE NOTICE FOR CARRIERS
STATE FORM 50676 (R2 / 12-02)

Agency: _____

Benefits Coordinator: _____
(Name) (Phone #)

Place a check mark next to the deleted coverage and payroll group.

MEDICAL:
___Anthem Traditional Plan
___Advantage
___Anthem HMO
___Arnett
___Humana
___M-Plan

___A – PAYROLL Date:
Last deduction: _____
Benefits terminate: _____

___B – PAYROLL Date:
Last deduction: _____
Benefits terminate: _____

VISION:
___Spectera

DENTAL:
___Traditional ___Dentacare

The following employees have terminated coverage with your company during the current open enrollment. Please make the necessary changes in your membership.

NAME SOCIAL SECURITY#

_____/_____
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